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Topeka
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THE USE OF INFANT TESTS FOR PREDICTIVE PURPOSES*

By SIBYLLE ESCALONA, Ph.D.†

At the time when psychological tests for infants were first developed, intelligence was generally thought of as an unvarying trait of personality. Each person was considered to possess a fixed amount of the trait or attribute named 'intelligence'; and the degree or quantity of intelligence possessed by a given individual was thought measurable by intelligence tests and reflected in a numerical score called I.Q. While it was recognized that adverse environmental circumstances might affect intelligence functioning, intelligence tests were thought the more valid, the more nearly it was possible to obtain the same I.Q. for the same person at different times or by means of differently constituted tests. The aim of infant testing was to be the assessment of the degree of intellectual ability which was considered to be already present as a potential awaiting realization—as it were—during the process of maturation. The value of a specific test was thought to be the greater, the higher the correlation between I.Q. or D.Q. (developmental quotient) obtained in infancy with I.Q. scores obtained at later ages.

Since then we have come to regard intelligence as a fluctuating function, a delicate interaction of many forces and structural conditions. We have learned to regard it as one among many functions of a total personality, and thus interdependent with environmental circumstances, affective states, and many other variables. In psychological testing generally this shift towards a holistic view brought about significant changes in the nature of the tests used, in test administration and evaluation, and in the very aims of psychological testing procedures. The measurement of an absolute level of ability or competence in regard to relatively isolated functions such as intelligence, has been replaced by an assessment of psycho-

* Read at 56th annual meeting of the American Psychological Assn., Boston, Mass., Sept. 6–11, 1948.

† Director, Research Department, The Menninger Foundation, Topeka, Kansas.

logical functioning as a whole; intellectual functioning being regarded as one important facet of the totality of mental processes.

The concept of diagnostic testing in this sense (as contrasted to psychometrics) has not yet been consistently applied to the psychological testing of infants. Psychodynamic personality theory brought a heightened awareness of the uniqueness of the developmental process in each individual. The traditional use of normative test scores tends to obscure individual differences. Perhaps for this reason many dynamically oriented students of infant psychology have lost interest in the formal testing of infants, and may thus have thrown the baby out with the bath. It is possible that developmental psychology has thereby failed to make maximal use of a valuable clinical and research tool.

In the course of clinical work with infants, primarily in behalf of child placement agencies, we have become interested in attempting to extend the concept of diagnostic testing to the youngest age group. Our assumptions, which are those of any field-theoretical dynamic psychology may be summarized as follows: Each behavior event—whether it be a baby focussing on a dangling ring, smiling in response to social stimulation or manipulating a cube—is determined by the structural conditions prevailing within the organism and in the psychological environment on the one hand, and by the forces existing within and without the organism at this moment in space and time on the other hand. In other words, the object of psychological inquiry (the test response) is not something located within the infant being tested, but a process of interaction between the infant organism and the immediate environment, i.e. the testing situation. Commonplace as such a statement may be, once taken seriously it leads to alterations in the recording of test data. More especially, it points to modifications in the analysis of test findings since the testing *situation* becomes the object of analysis quite as much as does the infant's behavior as such.

Implications in Prediction

This admittedly over-simplified formulation also has implications for the problem of prediction. It implies, for instance, that to the extent to which test scores obtained in infancy are regarded as predicting intelligence level in later life, as measured by subsequent intelligence tests—to that extent we are making a prediction not only about the subject but also about some aspects of the subject's environment at a later time. Theoretically, effective prediction of events can take place only when we know which variables will operate at the time for which prediction is made and the quantitative intensity with which these variables will be represented at the time for which prediction is made. This is the case with the more mature

sciences such as physics or chemistry. It is not possible, for instance, to predict the fall of a given stone from the law of gravitation, but it is possible to predict its fall if we know precisely the relevant conditions under which the fall will take place. When we make what we call predictions in clinical psychology, we always make a tacit assumption to the effect that certain aspects of the environment remain relatively constant, or are at least subject to anticipation.

The Gestalt psychological approach to the definition of what actually takes place when psychological tests are used for predictive purposes has another implication, which also has a bearing upon test administration and test evaluation: When speaking of human behavior and making the distinction between the person and the environment, we speak as though the environment had independent existence. For psychological phenomena, however, we know this to be inaccurate. Two situations which may appear identical, for instance the administration of the same test item on two occasions, may be perceived as entirely different by two different infants, or by the same baby at different times.

For example, at a given time a baby may be primarily interested in and responsive to social relations. Presentation of a test object may be experienced by him primarily as an approach from another person. Or, if the examiner is out of view, the primary experience may be the sensation of losing contact with a person, and may lead to searching movements apparently aimed at finding the examiner. Such searching movements may take the place of the anticipated goal—directed behavior in relation to the test object which had been intended to serve as stimulus.

Thus, prediction of a child's performance on a test to be given at a later time, or prediction of behavior in life situations, implies not only an anticipation of what the environment will be like at the time for which prediction is made, it also implies a prediction of the manner in which the child is likely to apperceive situations in which he finds himself.

To illustrate, we may refer to one such predictive attempt which appeared to be successful. An infant was first seen at the age of three months. At that time he gave every evidence of making unusually good developmental progress, earning test scores which placed him in the accelerated range. He was characterized by a very high activity level, bodily activity increased markedly in response to all stimulation. His capacity to tolerate delay or frustration seemed lower than that of most infants of the same age. At the three months age level, test performance reflects primarily gross motor coordination, vigorous responsiveness to stimulation and perceptual discrimination. At a later age however, tests are designed so as to also elicit fine motor coordination which requires inhibition of impulse, as well as problem solving behavior which implies delay in attaining a goal. It was hypothesized at the time of the three months test, that the infant might retain the characteristic of tending toward immediate discharge of tension, which would cause him to experience as frustrating

those tasks which require inhibition of impulse and an indirect approach to a goal. It was therefore predicted that tests at a later age were likely to yield average rather than accelerated scores. The child was re-tested at the ages of nine months and 22 months. On both occasions he was again noted to be a more than ordinarily active child. His total I.Q. dropped from the superior to the average range. Both times his performance on those items requiring fine motor coordination and those requiring a planful and indirect approach to a goal were passed at the low averge or borderline levels, or were refused altogether. Verbal items and those requiring immediate comprehension of a problem, however, were performed at high average and superior levels. Gross motor coordination remained outstandingly good.

Value of Infant Tests

In view of the theoretical considerations advanced so far, prediction on the basis of infant tests would seem to be an impossible undertaking. At best, such predictive statements as we venture to make must be regarded as part-prophecies. Yet, it is a fact that infant tests have proven their value. Such testing can succeed in detecting the mentally deviant at a very early age, often before pathology becomes manifest through pediatric or neurological examinations. In the absence of more fundamental insight it is a useful working hypothesis to assume—as have all students of developmental psychology except the most orthodox behaviorists—that the limits within which mental development can proceed are set by organismic characteristics which are present at the time of birth.* Consequently, infant testing is diagnostic testing if all observable behavior is viewed as determined by such organismic characteristics, reacting to and interacting with a multitude of extra-organismic variables which one attempts to comprehend in their totality.

The usefulness of speculations such as these may be measured by two criteria. (1) Does the application of these principles to infant test data lead to more valid information about and prediction for the subjects than could otherwise be obtained? (2) Does the observation, recording and analysis of infant test data in this general framework lead to fruitful hypotheses concerning the developmental process, and to methods by which such hypotheses can be validated? We believe that both these questions can be answered in the affirmative. Only brief mention of research opportunities will be made; the remainder of the paper will concern itself with the clinical validity of findings.

The comprehensive analysis of test situations can be applied to serial tests, and the findings from each test made the basis of predicting not only I.Q. results but the qualitative pattern of performance on the next

* This formulation deliberately evades the question of gene-carried characteristics versus environmental influences in utero; in the context of the problem under discussion this is a difference which makes no difference.

test. This should enable us to formulate hypotheses concerning those aspects of test performance (and by implication behavior generally) which are the product of identifiable organismic characteristics, which are observable at such an early age that 'learning' (experience influence) is not likely to have played an important role in their formation. We can obtain some answers to such questions as: Which of the characteristics of the infant, such as activity level, perceptual alertness, perceptual sensitivities, vigorousness of outwardly directed energy, etc., are actually stable, so that they can be recognized as being present from infancy through later childhood? Or, in what way does a given characteristic, or better a constellation of characteristics, influence the pattern of development? For instance, does a high activity level in early infancy consistently bring about a pattern of performance such as was reported for the one infant referred to above? It is believed that research of this nature, especially when combined with other methods of child study is one of the roads by which we may gain an understanding of general laws which govern development and which should explain rather than obscure the infinite variety of phenomena that at present are merely listed as 'individual differences.'

Research Procedures

Turning to the problem of clinical usefulness, we shall report on some tentative impressions which were gained in the course of operating an infant testing service for several years. The Menninger Foundation has offered such a service since 1944; it has been used primarily by child placement agencies. Our procedure has been to administer both the Cattell Infant Intelligence Scale, Form A, and the Gesell Developmental Schedules. Test findings were supplemented by histories, by interviews with whoever was taking care of the baby at the time (usually boarding-home mothers) and by clinical-observational procedures, some of which will be referred to below. The discussion to follow refers primarily to a total of 183 tests administered to 72 children. These numbers refer to that proportion of the total number of infants tested where the cooperation of agencies and of adoptive parents enabled us to re-test children after intervals varying from six months to several years. In some instances as many as five or six tests were obtained on a single infant, in others only two tests are being compared. In view of these irregularities, especially as to the age at which the babies were tested, and the intervals between tests, adequate statistical treatment of the data is impractical. The results of comparisons between groups of tests will be reported with the understanding that these gross comparisons suggest relationships which will have to be validated by more systematic procedures.

In administering tests, writing test reports and formulating predictive 'hunches' about each child, we attempted to keep in mind the general principles mentioned at the outset as they applied to each concrete situation. Among the practical consequences of such an orientation were the following: In writing test reports salient features of the infant's behavior were recorded, whether they were directly related to test performance or not. These included descriptions of the quality of the child's motility; his fatigability and capacity for muscular relaxation; respiratory and circulatory phenomena; the quality of his responsiveness to objects and to persons (both familiar and unfamiliar); the degree of differentiation shown in extra-test behavior; the situations which characteristically evoked manifestations of pleasure, of displeasure or of apprehensiveness; and characteristic modes of expressing these and other feeling states.

In evaluating test performance proper in relation to the above listed features of the testing situation and in relation to other circumstances which conceivably might have influenced it, we arrived at a judgment as to whether or not the infant's test performance elicited an 'optimal level of functioning.' This judgment referred to our impression as to whether the subject had performed in as mature a manner as was possible for this particular infant. Wherever qualitative analysis of test findings revealed striking inconsistencies, or where the level of functioning indicated in extra-test behavior was discrepant with the level of maturity indicated by the test results, or where signs of 'interfering' influences could be detected—in such instances it was judged that optimal functioning had not been elicited.

Those testing situations during which the child's best possible performance had probably not been elicited were further scrutinized in an effort to determine whether the child had been reacting normally to a situation which imposed undue strain; or whether the infant appeared to be in a condition which caused him to experience as stressful situations to which he might ordinarily adapt himself. The third alternative, in the interpretation of the meaning of such non-optimal test pictures is that they were produced by children whose development has been genuinely atypical (partial retardation; pseudo-retardation, etc.). Situational stress during testing may take many forms. For instance, at times the examiner, or the adult who brings the baby for the test, may be tense or preoccupied and thus fail to relate to the infant in a sufficiently relaxed and alert manner; or the room temperature may adversely affect the infant, or unusual noises may distract him, etc., etc. The second possibility, where the source of the difficulty appears to be a temporary condition within the infant, may be exemplified by babies who have recently suffered from minor physiological disturbances such as colds or digestive upsets. The third alternative is usually determined by comparing and combining the information received from the developmental history, from item analysis of test results, and from the qualitative aspects of test performance.

We were interested in knowing whether such a purely clinical and often partially intuitive judgment, as to whether or not 'optimal functioning' had been elicited during the test, had a demonstrable bearing on the validity of test findings. It was reasoned that a prediction as to future level of intelligence should be the more valid, the more nearly the test behavior in question represented the child's best level of functioning.* Upon survey of the 72 cases who were seen in early infancy and retested from one to six times subsequently it was found that—in our judgment *at the time of the initial test*—this initial test was considered to have elicited optimal functioning in only 47.2 per cent (34 cases) out of the total group of 72 cases. If our reasoning was correct the predictive accuracy of the test score obtained under optimal conditions should be higher than the predictive accuracy of test scores obtained under less favorable conditions. In other words we expected a closer correspondence between test and re-test scores for the group of 'optimal' tests than for the other groups.

It should be emphasized that the validity of test findings was questioned for predictive purposes only, in the 'non-optimal' group of tests. All 183 tests included in this survey were conducted under standard conditions. Infants were not accepted for examination (or the test findings were not entered in the record) when obviously hungry, sleepy or in discomfort. Infants who cried and did not respond to the usual methods of soothing were also excluded, so that the group of tests from which we anticipated comparatively poor predictive accuracy would be regarded as fully satisfactory in standard practice. As a matter of fact, many of these tests proved to be valid in detecting the presence of minor or major maladjustments which could at times be corrected. These tests often were diagnostic of the infant's functioning at the time, but not of his capacities for functioning under more nearly optimal conditions.

In the case of infants below the age of six months numerical results (I.Q. or D.Q.) have but little meaning since the total life span is so short that failure or accomplishment of only one or two test items has most impressive arithmetical consequences. Test results were therefore reported (to the referring agencies) and are here reviewed in terms of ranges of ability. These were: Retarded; Borderline-retarded; Low Average; Average; High Average; and Superior or Accelerated. Agreement between first test and re-test (as well as between subsequent re-tests where there were more than two) is thus regarded as good where the findings from the first and second tests place the child in the same range. It would be regarded as less good where the second test findings place the child in an adjacent

* Provided, of course, that optimal conditions again prevail at the time of the re-test, and that no serious environmental disturbances have occurred during the interval between tests.

range (e.g. a change from 'Average' to 'High Average'), and poor where the second test findings place the child in a range removed by one or more steps from the initial one (e.g. a change from 'Average' to 'Superior').

Table I shows that the predictive accuracy of test scores which were obtained under conditions judged to be conducive to optimal functioning proved considerably greater than that of test scores obtained under conditions which were satisfactory in terms of customary standards. These first findings encourage us to believe that the validity of estimates of endowment levels, on the basis of tests given during the first half year of life, can be significantly improved if the testing situation proper is used as a framework for a more comprehensive examination of the infant's functioning in all spheres, rather than as the only focus of attention.

TABLE I

Predictive Accuracy of Test Findings Obtained Under 'Optimal' and 'Non-Optimal' Conditions

TEST SITUATION JUDGED	TEST-RE-TEST AGREEMENT IN PERCENT OF CASES		
	Same Range	Adjacent range	Ranges one step removed
	%	%	%
Optimal	68	31	—
Non-Optimal	19	53	27

Behavior Deviations Observed

If this belief in the clinical usefulness of such comprehensive analysis of psychological data is justified, it becomes important to describe and identify behavior manifestations which suggest that a test was unsuccessful in eliciting optimal performance. It is implied that these same behavior manifestations may be diagnostic indicators of developmental disturbance. In the context of the present discussion a comprehensive survey of such signs would be inappropriate. In order to make more concrete the content of our main thesis, however, we shall describe briefly some characteristic observations of this kind.

Reference has already been made to characteristics of the testing situation which may detrimentally affect the infant's test performance. We shall turn to a consideration of factors which are primarily a function of the state of the infant at the time of test administration. One of the most frequent among these is the presence of unusual tension, which disrupts smooth and coordinated functioning.

If an infant who, as far as can be ascertained, is neither hungry nor

sleepy nor physically uncomfortable shows high muscle tonus, incessant squirming and wriggling, or marked muscular rigidity and tightness, or hyperactivity not relieved by periods of relative relaxation, this marked tension may be related to some other dissatisfied need or disruption of harmonious functioning. For whatever reason, the presence of this syndrome is likely to decrease the infant's attention span, though not necessarily his perceptual alertness. Signs of distress may occur more easily than is usual, and may prevent the infant from responding to test items which entail a mild degree of frustration. On the other hand, the presence of excessive tension may produce spuriously high test scores in the area of motor development. Tense infants may prematurely perform such actions as rolling from the prone to the supine position, supporting weight on their legs in the standing position, or crawling, not because of advanced neuromuscular development but as accidental by-products of excessive muscular rigidity and/or hyperactivity. We are far from understanding the significance of such tension states. We have noted them in infants not only during but sometimes for weeks after recovery from minor ailments of a physical nature; in infants who received grossly inadequate maternal attention; in infants who were being consistently over-stimulated; and in infants who were also showing other signs of imperfect functioning such as feeding and sleeping disturbances. In some instances we were totally unable to relate this observation to anything else we knew about the child.

Another kind of observation which has led us to question the predictive validity of some test results refers to the relationship between the child's achievement on test items and his extra-test behavior. It is rare to see an infant whose test results indicate markedly retarded development, and whose extra-test behavior suggests entirely normal functioning. Quite frequently, however, infants whose test performance places them in the low average or borderline group display spontaneous behavior which may be atypical and suggestive of some disturbance, but which nevertheless reflects alertness and discriminatory acumen, or the capacity for goal-directed behavior, of such a calibre as is incompatible with a genuinely low level of endowment.

We have also seen infants whose test performance reflected at least average developmental progress, but whose behavior otherwise lacked the expected amount of sensitivity and differentiation of affective expression. Such infants, for instance, may be seen to cry and laugh or grin appropriately, and to stare soberly, but they fail to show the finer nuances of near-smiling, of apprehensiveness, of curiosity and absorption which are ordinarily observed in infants of this age group. Paraphrasing a statement Anna Freud made in discussing the indications for child analysis, one might

say that infants whose behavior deviates from what is commonly seen in similar situations and from what is comprehensible in the situational context, present a special problem to the examiner, and test results must be interpreted cautiously until the deviation has either been understood or has disappeared spontaneously, as fortunately happens.

A third kind of finding which we have been led to consider as a sort of caution signal refers to intra-test consistency. Occasionally item analysis of infant tests will show an unusually wide gap between the maturity level of performance on some test items as compared to others. The significance of wide scatter, in this sense, will be understood only on the basis of a type of systematic study which is practically impossible with tests constructed as infant tests now available are.* The Gesell Schedules were found most useful for such gross scatter analysis as we were able to undertake. This test is divided into four areas dealing with motor, adaptive (intelligence), language and personal-social behavior respectively. It has been our impression that significant discrepancies among areas (e.g. motor development markedly superior to language development, or personal-social behavior markedly less mature than adaptive behavior) may reflect real developmental disturbances, even when scores for the total test fall within the normal range. In other cases scatter may occur within any one of these areas (e.g. when an infant does well on some attention items and poorly on others, or shows himself capable of purposive, goal-directed behavior on some test items yet fails to do so on other items a few minutes later). This type of intra-area scatter we have more frequently seen associated with temporary upsets or disturbances in the testing situation. It may be worth mentioning that in our experience, excessive scatter on infant tests was frequently associated with manifest clinical disturbance in the infant's adaptation to daily routines, such as feeding, sleeping or digestive disturbances. Only rarely has excessive scatter been noted in infants who proved to be of defective mentality.

Organismic Characteristics

Earlier mention was made of certain organismic characteristics which are observable in earliest infancy and which—should they prove stable characteristics—might exert an influence upon specific aspects of the developmental process. One of these characteristics which becomes apparent during

* The two principal obstacles to systematic scatter analysis on standard infant tests are: (1) That they present a continuum in terms of chronological age rather than in terms of specific mental functions so that items eliciting primarily 'attention' or 'reasoning' or discriminatory perception are unevenly dispersed over age levels. (2) That in all but the Cattell the number of items is different for each age level, and the same item often refers to disparate mental functions.

psychological testing, is activity level. As described by Fries* this refers to the relative amount of bodily activity shown by the infant. Fries hypothesized that a strong, medium or weak need for physical activity is constitutionally determined, though capable of modification through experience. An estimate of activity level has been included with each of our test evaluations and a survey of the serial test reports shows that we have seen very few extreme changes in activity level. Where children changed from being very active to being under-active (with the exception of two instances) this change was accompanied by severe maladjustment during the second or third year of life. However, minor modifications of activity level in the direction of the mean were observed quite frequently. That is, infants who during the first few months of life were rated as showing a low activity level, might later on display a low-medium activity level; some initially hyperactive infants later fell in the markedly active (but not overly active) group.

Two other characteristics have intrigued our imagination and led to speculations concerning their possible significance for development. One of these we refer to as *sensitivity*, by which is meant the degree to which the infant proves responsive to minimal stimulation (low threshold) or to nuances of stimulation whether it be in the various sensory modalities, in regard to social interaction or object stimulation or, as is more likely, a combination of these. The second of these characteristics is more difficult to describe. It appears to be related to that which later develops into such traits as deliberateness and persistency. The closest approximation we can find at the moment would describe it as the capacity to focus and channel energies upon a given task. Among our group of babies, those who possessed either of these characteristics to a marked degree in early infancy, continued to be so characterized during the second, third and, where we were able to follow them up to that point, the fourth year of life. Since the number of children with whom serial testing was carried out is small, these first impressions will surely require modification as experience accumulates.

If it is true that characteristics such as these, which refer to some general aspect and/or determinant of functioning, can be recognized during the first six months of life, and if they can be shown to remain characteristic of the child in later life; then they are important for predictive purposes. One of the facets of prediction, as mentioned previously, concerns the manner in which the subject for whom prediction is made will apper-

* Fries, M.E. and Lewi, B.: Interrelated Factors in Development. *American Jour. of Orthopsychiatry*, 8: 726, 1938.

Fries, M.E.: The Interrelationship of the Physical, Mental and Emotional Life of a Child from Birth to Four Years of Age. *American Jour. of Dis. of Children, Vol.* 49, 1935.

ceive the world, or situations in which he is placed. It is our impression that more general characteristics of the kind referred to partially determine the activities, tasks and situations which will be interesting, pleasurable, disturbing or frustrating to the child. Observations of this nature, therefore, might enable us to predict not so much the level of mental functioning, as something about the quality and specific pattern of mental functioning at a later time.

Summary

In summary; attention was drawn to the implications of a field-theoretical point of view for the administration, evaluation and predictive uses of infant tests. Important among these implications are the following: (1) The object of examination and measurement is the process of interaction between an organism possessing certain structural and dynamic properties and a situation which also has structural and dynamic properties. (2) Prediction of level or kind of mental functioning in the future implies a prediction concerning not only characteristics of the subject, but prediction concerning the constellation of environmental variables which are expected to operate at the time for which prediction is made. To the degree to which environmental circumstances are guessed at, or assumed to remain constant, prediction on the basis of psychological tests is in effect prophecy. (3) Ultimately prediction should be made in terms of the manner in which the (relatively stable) psychological characteristics of the child will selectively modify his perception of the objective situations in which he will be placed.

On the assumption that comprehensive analysis of the entire testing situation permits an approximate judgment as to whether or not 'optimal functioning' was elicited from the child, two groups of test-re-test series were compared for predictive accuracy. It was found that prediction of subsequent level of intelligence was accurate more frequently in the group of tests initially judged to have elicited optimal functioning. Also, the degree of error in prediction, where error occurred, was greater for the group of tests, which were held to have elicited 'non-optimal' functioning. The number of cases involved is too small to permit adequate statistical treatment so that the reliability of these findings remains to be confirmed.

It was concluded that the predictive accuracy of infant tests in respect to intelligence level can be improved, and that prediction of qualitative aspects of intelligence functioning can be attempted, if the test results proper are brought into relationship to the results of clinical observation in the context of the total testing situation.

A PSYCHIATRIC FABLE

By KARL MENNINGER, M.D.

There was once a psychiatric resident named Dr. John Smith.

He had a very ordinary name and he was a very ordinary looking person. He was a short fellow and rather fat; he wasn't handsome and he had no way with the girls. So he wasn't married and he was no social lion.

He didn't write easily, and his case abstracts were not remarkable so he rarely got any praise from the service chiefs.

He didn't seem to grasp all the intricacies of psycho-dynamics; his colleagues said his presentations were rather dull and the attending men and consultants never seemed particularly impressed. But the nurses and aides on his service thought he was a man they could trust, and his patients loved him.

He didn't get in on the rush to make application for a training analysis, so he wasn't among the early selectees. When a seminar program was announced he read up on the subject in the library, but he was too diffident to offer any comments in the discussion and his colleagues thought he didn't know anything about the subject.

So he wasn't very well known, and certainly not very popular; he couldn't be called charming or brilliant. The psychological tests didn't put him in the "very superior range." He wasn't made chairman of anything or secretary of anything, or even sergeant-at-arms.

But it was observable that he ran his ward very well indeed. He knew all of the nurses and all of the aides and all of the patients, and they all knew him. He went on picnics with the patients and played cards with the aides at some of their social events, and helped the nurses to get up a dance on Halloween, and fixed the radiator in the men's toilet one cold, winter morning when the maintenance men couldn't be found. He searched through four wards hunting a clerk-typist that had been called on the telephone; he didn't want her to miss a possible date. He relieved an aide one day while the latter went to the Post Exchange on a personal errand and when another aide's wife died, he went to the funeral. He fixed a patient's cigarette lighter and took a patient's mother to the Contact Office because she was afraid she might lose her way. He listened sympathetically to a social worker tell a very long, weary story about her nephew's alcoholism without giving her the impression that he was bored or busy. He was frequently seen on his wards Sunday afternoons and always on holidays. And his patients all seemed to improve even though he received a low mark in the "Psychotherapy" course.

Toward the end of his third year of residency John Smith was wonder-

ing where he would go because he didn't suppose any of the good positions would be open to him. He doubted if he would have a chance at any of the prize appointments. In fact, he wondered if he was any good at all as a psychiatrist.

About that time the residents took a poll to name the most popular, the most brilliant, and the most likely to become successful from among them. Of course, John Smith wasn't elected any of these.

But then the senior residents and the faculty took another poll. They voted on the resident considered to be the best all-round psychiatrist in the hospital. To the surprise of a few people, John Smith's name led the list.

THE AUTISTIC ATTITUDE IN MEDICINE AND SCIENCE*

By ALFRED PLAUT, M.D.†

The terms autism and autistic thinking were coined by Bleuler[1] in 1912, in a paper entitled, "The Autistic Thinking." Bleuler writes, "starting with the dream of the boy who plays the general on his hobby horse, through the poet who, in a piece of art, deals with an unhappy love and transforms it into a happy one, down to the hazy hysteric patient and to the schizophrenic who in his hallucinations sees his most impossible dreams fulfilled, there are all transitions belonging to one series with essentially quantitative differences only." After having stated that autistic tendencies intrude easily into ordinary thinking, Bleuler continues, "even in science, things one likes to believe are quickly proven, and opposing arguments are easily ignored." Seven years later, in 1919, Bleuler[2] published a book bearing the title, *Autistic, Undisciplined Thinking in Medicine and How to Overcome It.* In the preface he words the definition beautifully. "Autistic . . . means based upon the primeval soil of wishes and imaginations instead of upon reality and strict logic conclusions." Bleuler insists that scientific thinking is not the real opposite of ordinary thinking which is tainted with autisms. "In finance and business," he writes, "thinking is more exact than in a science."

The words autism and autistic have become an integral part of psychological vocabulary.

Bleuler's statement that only one medical paper out of 1,000 fulfills the requirements of exact statistical methods sounds too pessimistic. But Bleuler deals mainly with papers on therapeutics, and in this field his statement may be almost adequate. His book deals at length with methods of treatment that have given "marvelous results" and have been found worthless afterwards. He also talks about papers concerning cures of diseases that need no treatment. The great danger of autistic deception in therapeutics has been succinctly expressed at a Mayo Clinic staff meeting in the words, "It is very easy to become a sincere and even honest quack."

It is not my intention to speak about such blatant manifestations of the autistic attitude; I am more concerned with subtle, insidious, but not less dangerous instances of autistic thinking in various fields of medicine and science. I shall further attempt to trace autistic thinking in some

* Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration. Presented at Winter VA Hospital Forum, Dec. 7, 1949.

† Chief of Laboratory Service, Winter VA Hospital, Topeka, Kansas.

phases of the development of science, and to evaluate its relation to our philosophy of life. The latter might be studied by analyzing the phrase, the world and I, or as it reads for many people, I and the world. The world may be—in this context—either the whole world or a small object under investigation. In a problem of basic medical science, e.g. anatomy or pathology, the world generally is represented by a single object under observation. A simple description of such morphological detail would seem to be independent of the observer's ego, not counting technical mistakes. This is not the case, as can be shown by an example.

The kidney tubule, as will be remembered from the histology course, begins as a continuation of the capsular space which surrounds the capillary loops of the glomerulus. Any routine slide of a human kidney shows this continuity. But, less than 20 years ago a voluminous paper was published in a reputable journal telling that the kidney tubule is closed at its upper end, and that, in consequence, one must start from scratch with theories of kidney function. The author of this paper worked with several methods each of which must have shown the opening of the capsular space into the lumen of the tubule. But he just could not see it. A solidly anchored preconceived idea prevented him from seeing what must have been under his eyes. The autistic mechanism, the unconscious wish of having his pet theory proven, simply was too strong.

Another striking example comes from the field of physiology. A professor of physiology worked on the vestibular apparatus. He subjected guinea pigs to various kinds of damage. The outcome of his experiments was judged from the way the guinea pigs rotated in falling, namely, to the right or to the left, when dropped from a height of about three feet. All experiments had the predicted result, which is not astonishing since the professor dropped the animals himself, and by hand. If anybody had hinted to the old man that he gave the guinea pigs a twist in the desired direction while releasing them, the insinuation would have been brushed aside with honest indignation or with a condescending smile. These are extreme examples; their psychological basis is easily understood.

Let us follow this psychic unbalance we call autism into the smaller things of our daily medical work, diagnosis for instance. The pathologist, who for decades has discussed diagnostic problems with the clinicians, hears certain rare diagnoses quite often while he seldom encounters the corresponding disease on the autopsy table. Periarteritis nodosa is one of them. Why should we mince words? Somewhere under the surface of consciousness, we feel that the rarer and queerer our diagnosis, the bigger a fellow we are, and so we prefer to diagnose a rare disease. The persistent lack of verification, one might think, will cure a man of this habit; it does not. We generally forget that we made such a wrong diagnosis, but the one exceptional case whose outcome confirms us will be graven in our mem-

ory. It is the same mechanism by which "dreams come true" that may have been dreamed 50 times without being remembered, and once are brought to our conscious attention when we actually meet Mr. X, about whom we have dreamed, on the street the next morning.

Autism may be related to a group as well as to an individual. I realize how difficult, if not impossible, it may be in the single instance to break with this entrenched system.

One easily underrates the psychological danger of working for a group, be it a pharmaceutical concern, a department in a university, a government, or a hospital, if one thinks only of deliberate falsifications. The danger is more subtle. The influence of the atmosphere, in which a man works, will make itself felt in his choosing one of several possible explanations, without his being aware of this influence. His thinking becomes autistic in relation to the group. People who promulgate fantastic results and theories that conform with a creed, a political idea, or a business interest, probably are less frequently dishonest than we believe. The psychological mechanisms of anthropologists and geneticists under totalitarian governments might be more complex than it appears from the numerous articles we have read about Nazi race theories or Soviet genetics.

We have to be aware of autistic influences even in the simple process of searching the literature. An ambiguous title, referring to an old volume of an obscure journal, will make us "feel sure" that this has nothing to do with our topic when our subconscious desires that we should be the first to write about this topic. If we were intent upon proving that a certain fact was known 70 years ago, the ambiguous title would appear to us as a possible lead and we would read the old paper.

Controls, the backbone of scientific work, must be safeguarded against our autistic weaknesses. Assume that somebody has found a certain micro-organism in the lymph nodes of patients who have died of an unexplained disease. He thinks that this micro-organism is the cause of the disease. He then examines lymph nodes of patients who have died of other diseases in order to make sure that the micro-organism in question is not there as well, which would invalidate his theory. In studying these controls, he must time himself with a clock to make sure that the controls are studied for at least as long a time as the other slides; and there is no apparatus to guarantee the same intensity of search. Efficient safeguards do exist; one can, for instance, cover the labels of all slides in such a way that he does not know what slide he is studying. It appears doubtful whether such safeguards are resorted to by every investigator.

The choice of illustrations for a scientific paper is a rich source for autistic misrepresentation. Numerous photographs may be available, the magazine may not print more than eight. Am I, the author, going to pick the most representative ones, or am I going to pick the ones that best illus-

trate my personal interpretation? The danger is even greater when the results of an experiment are shown in a movie. Film strips must be cut, and it is asking much of one's unselfishness to cut the film in an entirely objective way while one favors a definite interpretation. When I consider parts of the film repetitious, or technically not very good, they might just be the ones that do not support my interpretation. Please remember all the time that I do not talk about conscious misrepresentation.

A man may soothe his fears of having been autistic by proudly pointing to the mathematical formulas in his manuscript. Very well, but what about the observations which furnished the material for the exact calculations, were they entirely independent of motives? The use of figures—and this is an amusing paradox—has produced outstanding examples of autistic literature. The holy numbers of religions have been used, numbers taken from astronomy, and finally, from the menstrual cycle of the human female, which, as I think by sheer accident, is about as long as the cycle of the moon. Judging from such books, all these numbers play an important role. Every author has picked those phenomena whose time relations fitted his theory; there are enough of them to suit many different numbers. A handsome volume of 600 pages, filled with mathematical symbols "proved," in 1906, that all happenings in human life are spaced in sums or differences of 28 and 23. This includes birth and death, conception and the first movement of the foetus, but also the time of the first stroke, the occurrence of infections, and finally, the time of great psychic activity in the life of geniuses. The objection that any figure can be arrived at by such methods is waved aside as "cheap" in a footnote. This book, which was taken seriously by many people, shows better than anything else, that mathematical formulas do not protect us from the worst autistic fallacies.

One powerful autistic motive is a desire to appear clever, and to fulfill this desire at the lowest possible cost, with the least effort. Hence, simple mechanical explanations are readily utilized. Unfortunately, most biological processes are extremely complex, and the chance that a simple mechanical explanation will hold water is pretty slim. Progress in numbers of problems can be traced through the years as the replacement of simple explanations by more complicated ones.

For example, when intracranial pressure rises, the pituitary gland is flattened; it is more flattened in the center, corresponding to the diaphragma sellae, because in this central area, there is no dura mater. The result is the boat-shaped pituitary gland. This reasoning appears flawless, but, unfortunately, pituitary glands of exactly the same shape occasionally are found in skulls with normal pressure.

The simple mention of the term "choked disc" will start the neurologists among you on similar lines of thought.

Every field in medical science yields a goodly harvest of widely accepted

insufficient or misleading simple explanations. A list of some outstanding examples was made 25 years ago.[3] The discussion of suicide in Karl Menninger's *Man Against Himself* shows the insufficiency of the simple explanation in convincing detail. Thousands of problems could be solved more quickly if we were not too fast in obscuring them by opinions. Our ready acceptance of explanations is prompted by our desire to know, by our wish to be rid of a problem, by our urge to feel clever, in short, by our autism. It is a serious drawback to scientific progress. Once a theory is accepted most of us stop looking for another one, and the problem remains unsolved.

Simple, mechanistic explanations have been proposed and accepted by generations of scientists, who, at the same time, considered life processes as something apart from other phenomena, as the effect of a mysterious vital force. Even men of genius were not struck by the discrepancy. Xavier Bichat, the founder of the science of histology, was a vitalist. But he assumed that the motion transmitted to the brain by the arterial pulse was an essential factor in brain function.

The antispiritual, materialistic tendency of the nineteenth century was a boon to man's desire of having simple explanations for the phenomena surrounding him. Darwin did it for us in the natural sciences, Karl Marx in economics and sociology. In the process of our emerging from this period, the most important aspect is that of avoiding the one-sided explanation. A lecture given by the physiologist, Max Verworn,[5] about 40 years ago, bore the title "About Causalistic and Conditionistic Thinking"; it was an eye opener for many of us. It told us that a phenomenon is the result of a group of factors, and that our designating one of these factors as "the cause" is often arbitrary. The discussions about "the cause" of a war, or of a single crime, furnish the best examples.

We cannot be satisfied anymore with a one-sided explanation for a biological phenomenon like a disease. We know, for instance, that the invasion of the human body by the tubercle bacillus is not "the cause" of the disease tuberculosis. We know about other important factors, in the patient and in his surroundings, even if we do not understand all of them. We do not look at the animal organism as if it were a machine consisting of a few cogs and levers, we rather think of the living body and its organs as of fields of energy in which all points are interrelated.

The mechanical, the simple, the vitalistic, the teleological explanation, they all have a common denominator—they are anthropomorphic. They are patterned on ourselves. Thus autistic thinking appears as a basis of our general theories in biology, almost of our philosophy, our *Weltanschauung*.

A glance at biology of 200 years ago may be instructive.[4] "The basic powers of animals . . . must necessarily stem from the perfect wisdom and the perfect goodness of the Creator who wanted to give all living beings . . . a pleasurable enjoyment of their existence, endowing them with the

best adapted means for the requirement of so many thousand different kinds of living." This is quoted from the preface of a book on the builders' instincts of animals, published in 1762. Was the author, we must ask, not aware of the fact that the net of the spider perhaps makes the spider happy, but certainly not the entangled fly or moth that struggles frantically until the spider comes and sucks it dry? The book even describes how skillfully some animals crush the bones of fish they have caught, in order to make them thin enough for being swallowed. And this author, who was familiar with scientific literature, was by no means devoid of critical discernment. He refused to use observations of old authors, he realized that observation of domesticated animals might be misleading. But he failed to see that it might be unpleasant to be eaten alive. And why? Because of his deep conviction of the perfectness of Creator and creation.

The psychological attitude of this man would have no value for our discussion if he had been an old-fashioned theologian. But he was a free thinker, a heretic. He denied miracles, he did not believe in revelation, he trusted neither the Old Testament, nor the New. He did believe, however, that God is the Creator of the world, that His wisdom and goodness are conspicuous in the world, and that these truths are discoverable by reason. Now we understand that he simply had to see perfection in everything in nature, otherwise his belief in his natural religion would have broken down and he, himself, with it. This highly cultured, many-sided man revealed the autistic basis of his philosophy by stating that "we study nature for the adoration of the Creator and of our own perfection." Since man, since he himself, was the peak of creation, creation had to be perfect; and this esoteric dogma prevailed over the simplest reasoning.

A century later, Darwin's origin of species appeared and, before long, the concepts of the animal nature of man, of evolution by survival of the fittest, of the struggle for existence, began to dominate the mind of western man. Did Darwin's theory represent a definite turning away from autistic thinking in biology? I do not think so. Darwin studied and described numerous phenomena in the animal kingdom that fit his theory marvelously. But half an hour's walk through a zoological museum, especially through the aquarium, will convince an unprejudiced observer that many of the unending varieties of shape and color of animals cannot be explained as useful. Darwin, after having conceived his idea, naturally and autistically, picked the items that fitted the theory. He was aware of the many unexplainable things and, with the modesty of the great man, ascribed the lack of an explanation to our ignorance.

Another aspect of Darwin's theory brings it into line with autistic thinking. The idea that competition, destruction of the weak, and survival of

the stronger, are the main principles of biological evolution is anthropomorphic; it transfers an idea of man to the whole animal kingdom.

Many modern biologists doubt the universal applicability of Darwin's theories. On the other hand, we hear more and more about mutations, about changes in organisms that seem to be less dependent upon observable outer influences and that are transmitted to the progeny, thus representing a step in evolution. And the theories of heredity we hear about concern the chance distribution of the minute particles of the germ plasma, of the genes. It almost looks as if, in our biological theories, we were actually emerging from autistic anthropomorphism since neither a humanlike, omniscient and benevolent regulating power, nor an all too human brutal struggle appear to us as the basis of the living world, but rather the chance grouping of the smallest known living particles, the genes.

Such chance groupings, namely of the smallest particles (or units) of energy, also represent the end of the tragicomedy in which conceited man believed himself the center of the universe. "His" earth was the center around which the celestial bodies circled. And deep in their hearts, many people even today forget to how humble a place Galileo and Darwin have relegated us. Certainly they know that the earth revolves around the sun; but knowing and knowing are two different things. They also know that that man is a mammal, little different, anatomically and physiologically, from other mammals, but still, in some recess of their heart, they feel that the sun should and does rise in the east and travels around our earth, which is the center of the universe, that everything revolves around us.

We have discussed the influence of our autistic attitudes upon theories in medicine and science. Our modes of expression, our writing and talking, also reflect these psychological attitudes. This, however, would represent the substance of another paper.

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NURSING ASPECTS OF THE TREATMENT OF LOBOTOMIZED PATIENTS*

By EVELYN FRIEDMAN, R.N.†

Although prefrontal lobotomy as a means of treatment of the mentally ill was introduced by Moniz in 1935, the nursing aspects of this form of treatment have been neglected in the curriculum of nurses' education programs. Only recently have personnel responsible for the teaching of nurses undertaken to investigate this area of nursing care. The systematization and organization of pertinent data, needed for nurses' education on this subject are still in the pioneer stage. One obstacle in gathering material has been the reluctance of those working in daily contact with lobotomized patients to record and publish their observations and findings.

Recently, The Menninger Foundation received a letter from a psychiatric nursing instructor in a Canadian mental hospital requesting literature concerning postlobotomy nursing care. Because of the very limited literature on this subject and the small number of such patients under observation at the Menninger Hospital at the time, the letter was referred to the nursing staff at Winter Veterans Hospital, and the writer was stimulated to record her observations concerning the postlobotomy care being given there by the nurses and aides. Obviously this paper cannot record everything that goes on in the postlobotomy treatment involving the nurse, aide, and patient; only the most outstanding problems and the methods used in an attempt to handle them are briefly described in this paper.

Our treatment of the postlobotomy patient is divided into two parts.

The first stage is the immediate postsurgical treatment on the neurosurgical ward. This is an open ward and the patient remains there from seven to ten days. During this time, he has three special aides assigned to cover each twenty-four hour period.

Aside from routine postoperative care and close observation, little attempt is made toward re-education except in the field of food and bowel habits. These patients often have, or develop, undesirable habits such as the retention of food without swallowing, dawdling over food, playing with utensils, rearranging of tray, etc. This seems best dealt with by a friendly but firm attitude, assisting the patient to eat, coaxing and "kidding" him. The tray is left for a period varying from thirty minutes to one hour and if he has not eaten, it is then removed. Occasionally the patient will miss

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† Staff nurse, Winter Veterans Hospital, Topeka, Kansas.

several meals through procrastination. The principal thing is not to leave him alone with the tray. He will do far better if encouraged, prodded and coaxed.

Bowel and bladder training is begun about the third day by taking the patient to the lavatory at regular intervals. These routine visits to the lavatory are continued until the patient no longer needs to be reminded —usually four to six weeks. The night schedule is kept up the longest. He will display no emotion over accidents, and we try to point out that we are sure he can remember to tell us in the future when he needs to go to the lavatory, and then see that he is reminded to go. Locking himself in the toilet and playing in the washbowl are gently but firmly discouraged.

Masturbation or holding and fondling of genitalia begins postoperatively and is usually quite persistent. Our policy has been to attempt to occupy the patient with a more socially acceptable pastime, such as reading, looking at magazines, playing solitaire, checkers or simple card games, etc. He is not told that he is bad or that it is naughty, but rather that this is something people do not do in public and that it is considered to be poor manners. This seems to lessen his exhibitionism and eventually seems to result in lessened interest.

Constant vigilance is necessary during this period to keep the patient from removing his head cast and dressings. All patients attempt to remove their casts and dressings, and if successful they must immediately be redressed before contamination occurs. After removal of head dressings and healing of the incision, the patients are given stockinette caps to wear and are transferred to the closed lobotomy ward.

The emphasis in the closed lobotomy ward is placed on attitude and re-education. The lobotomized patient's behavior closely simulates the behavior of a willful, untrained child in both actions and personality. The operation will have diminished the intensity of his reactions, e.g., if depressed, his depression and crying spells will be lessened and eventually disappear; if paranoid, his system will still be intact but the anxiety and feeling will be markedly lessened; if a mute catatonic before, he will slowly begin to express his hitherto unexpressed feelings.

Inertia and procrastination are the big stumbling blocks confronted by personnel in attempting to re-train these patients in matters of personal hygiene, concern for the opinion of others and for the future. Their attention span is shortened; they are suspicious, irritable and easily distracted.

Being people with personalities, however warped, makes each a personal problem and we have found that certain personnel can secure cooperation from certain patients because of some personal appeal to the patient. Sometimes the nurse is more successful with a certain patient than a male aide, and vice versa.

These patients are quick to detect dissension among personnel and will

use it to their advantage whenever possible. Consistency is important as is genuine liking for the patients. Personnel who feel ill-at-ease and are unhappy are encouraged to transfer to another service if individual counseling by the doctor does not help them.

The management of vulgarity and cursing depends upon the degree of contact with reality that the patient has reached. If the patient is not in good contact, such behavior is ignored; it is also ignored if the patient seems to be doing it for attention. If he is oriented to reality he is chided, privately reprimanded by the nurse, and reminded that at home such language would not only be considered unnecessary but also improper.

Under the heading of personal hygiene, the following are the principal problems: shaving, brushing teeth, hair cuts, nail care, bathing and untidy clothing. We encourage the patients to shave daily. At first this takes them about one hour. We prefer to let them shave themselves; after having been shaved over a lengthy period of time on the regular closed ward, this is all the incentive that is necessary. Sometimes it is necessary to shave them a few days to convince them that you intend for them to shave. In this case, we try to display no antagonism, but rather a matter-of-fact attitude. Sometimes they will shave for the nurse or their favorite aide, or if they can be alone in the bathroom. A matter-of-fact "it's time to shave" works best with some; with others, one uses an entreating attitude to better advantage. If they prefer their own shaving equipment, it is allowed. The only absolute rule is that the nurse keeps all the razor blades locked up and hands them out and collects them daily. An aide is always present while they shave to see that no accidents occur and to encourage them not to loiter unnecessarily since others are waiting.

The tooth brush locker is in the bathroom and each brush is labeled. Many prefer to keep all their toilet articles in their bedside tables and this is permitted if they are competent to do so. Most of them brush their teeth, except when angry; a few have to be reminded twice daily. Using a dentifrice of their own selection is usually a sufficient incentive.

The hospital provides a haircut, free of charge, once a month. We call the patients into the office one at a time. We never force them to accept haircuts but try always to maintain a positive attitude, coaxing them, offering to cut it at their bedside, and reminding them how bad they will feel if they are the only ones with untidy hair.

Nail care is something we encourage each patient to do personally, but if a patient refuses, the nurse usually has little difficulty in doing it for the patient. Often the patient seems to like this "mothering" from the nurse.

The patients are bathed in the evening and most of them are very childlike in that they are reluctant to get into the tub or shower and even more reluctant to get out. Occasionally it has been necessary to turn off the

water supply or take the plug out of the tub, but persistent coaxing is usually sufficient. No washbowl plugs are allowed as the patients love to dabble and play, and will gleefully flood the floor if a stopper is available.

Untidiness in dress is manifested by wearing soiled clothing, leaving out shirttails, leaving genitalia exposed, and wearing pajamas under clothes. First, we try to have the patients wear their own clothes, particularly shirts, underclothes, shoes and stockings. They are not allowed to go to off-station events, such as baseball or football games unless well-groomed and clad in personal clothing. Then we give generous praise for neatness. Mild criticism and reminders are usually sufficient for those who do not respond to these measures.

These patients are very sarcastic and cruel in the remarks they make about each other and personnel. Their sense of fair play, decency, good manners, etc., are appealed to in an effort to halt and minimize these habits. Rejection by the personnel is sometimes employed effectively as a means of discipline.

The patients continue to be preoccupied with their operative incision for about one month. By this time, their hair is beginning to cover the area and interest is gradually lost.

They are encouraged, but *not* forced, to participate in such activities as occupational therapy, movies, gym, swimming (no diving), listening to the radio, reading, visiting, writing letters, playing checkers and simple card games, attending spectator sports, picnics, church, and taking walks. Any special interests or talents are utilized, such as in music, ceramics, gardening, printing, sculpturing, library work, typing or shorthand, etc.

Vigilance is necessary as these patients are subject to seizures from immediately postoperatively to six months postoperatively, even longer in rare occasions. These may be regular but are usually infrequent and are controllable with anti-convulsants.

Essentially, rehabilitation is accomplished through (1) re-training in personal hygiene, and in socially acceptable behavior; (2) inducing the patient to take an interest in the future, and (3) teaching the family to accept the patient *as he now is*. This latter function in our hospital is handled chiefly by the social worker, here and in the home locality, and by the ward doctor and individual therapist, if the patient has one. When members of the family visit, the nurse may help them to understand the patient.

The following is a list of reference material which may be helpful, although the material I have discussed is not taken from these sources, but is only a summarized account of our rehabilitation work as nurses.

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CHRONIC DIARRHEA WITH PSYCHIC CONFLICT*

Case Report†

By PAUL KERSTEN, M.D.‡

This shy, inhibited, 28 year old man was admitted to Winter Hospital in July, 1949, because of diarrhea which had existed for ten months. Although stool examinations were negative, barium enema studies revealed (1) a lack of mucosal pattern in the region of the descending and sigmoid colon, and (2) enlargement and widening of the cecum and ascending colon.

In October, 1948, after drinking a small amount of alcohol, the patient had developed nausea and vomiting with diarrhea of severe degree but short duration. Periodic diarrhea continued until January, 1949, when it became persistent. The diarrhea usually followed meals, was sometimes watery, but was not accompanied by fever or bloody stools. He often had two or three foul stools following a meal.

History: The patient, oldest of seven living siblings, was born and reared in Arkansas where the family made a marginal living and led a somewhat itinerant life. The father died of pneumonia when the patient was one year old. When he was three, the mother was remarried, this time to an honest uneducated farmer who was never able to get ahead and who, after years of living on a low cultural and economic level, had lost all ambition to succeed. He was a stern man when the patient was a child, but as other siblings appeared he became less harsh.

The patient had a high regard for the integrity of the stepfather, but could not accept his complacency. The mother was a kind, uneducated woman, toward whom the patient felt duty bound. He had a strong desire to help the family raise themselves from the economic and social morass in which he saw them.

The most important sibling in the patient's emotional life was the second younger brother, described as an irresponsible, lazy spendthrift to whom the patient was unable to say no. The patient felt he should assume a father's responsibility toward the younger brothers and he wanted to help them raise themselves to a higher economic level. This desire was met with

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†From the Psychosomatic Section, Winter VA Hospital, Topeka, Kansas. Sidney Rubin, M.D., Director.

‡Resident, Menninger School of Psychiatry, Topeka, Kansas.

apathy by the parents and siblings, and resulted in frustration to the patient.

The migratory existence of the family interrupted the patient's education so that, although an intelligent, energetic youth, he did not finish the eighth grade until he was seventeen. He then left home to join the Civilian Conservation Corps in order to improve himself physically, educationally, economically and socially and to remove himself from his home environment. After two years in the CCC, he returned home, completed the ninth grade and then went to work in a West Coast shipyard. There he still helped in the financial support of the family.

He enlisted in the Army in 1942 and served 27 months in the European Theatre of Operations. In spite of some anxiety-provoking situations, he did not develop any symptoms. While in the service, he continued to send considerable amounts of money home. Following his discharge in 1945, he returned to his parents' home but soon left, feeling again that it did not offer him the cultural advantages he wanted. He came to Kansas in 1947 and since then has been steadily employed in a mill.

In 1947 he picked up a girl in a bar and continued to go "steady" with her in spite of feeling that he did not love her. He felt "duty bound" toward her because of sexual activities with her and she, in passive ways, fostered this feeling. He relates the "duty bound" feeling to guilt over an abortion she had had performed in 1948 without his knowledge. At the time of admission, the patient felt himself inextricably caught in this relationship.

In mid 1948, the "problem" brother came to live with the patient, causing chronic anxiety by his irresponsible activities, constant borrowing of money and use of the patient's most prized possession, his automobile. Against the patient's wishes, this brother accompanied him on a week-end visit home in October, 1948. Because of this brother's demands and those of the parents and other relatives, which this "duty bound" patient felt he had to meet, he was unable to enjoy himself. He describes the week at home as being miserable and causing a state of tension and mounting anger. On the night of the onset of the present illness, following a dutiful telephone call to his girl friend, he felt even more angry, lonely and frustrated. Just that day he had again suggested ways to the parents whereby they could help themselves but had met only apathy and rejection. He spent that evening at a local night club, sharing a pint of liquor with another couple and a physically attractive married woman he had picked up. During the evening, the patient drank little and was enraged by the passes which his pick-up date made at other men. On the way home, though not particularly aroused sexually, he made advances to this woman and was rejected. He became nauseated and almost immediately began to suffer from the vomiting and diarrhea which led ten months later to his hospitalization.

Course of Treatment in Hospital: Shortly after psychotherapy began, the patient was taken off sedatives and antispasmodics. Effort was made to help him verbalize and recognize his trapped and guilty feelings toward his girl friend. Soon he became free of symptoms except on week ends when he was with her. Recognizing his true feelings toward her, he then broke off the relationship and became completely free of symptoms. Attempts were made to show the patient how, because of a lifelong pattern of compliance to others in opposition to his own desires and needs, he had allowed himself to become so involved—how he had frustrated himself. He came to recognize this pattern in his relationship to his family as well as to his girl friend. As treatment progressed, he became more active and energetic and passed examinations for high school graduation with excellent grades. He then asked for vocational guidance. After a period of readjustment following discharge, he planned to attend trade school. He was free of symptoms when discharged from the hospital in November, 1949.

Summary of Discussion by the Hospital Staff

This man has always been an idealist. We should like more information about the development of his drive to succeed, so different from the rest of his family. Perhaps because of this difference and the resentment that met his efforts, he seems to have opposed his own strivings to succeed by an excessive zeal to please. He was almost unable to refuse a request, and found himself trapped whenever a demand was made on him. His inability to refuse made him see the people closest and most friendly to him as the greatest threat to his freedom. Caught between the impulse to go forward and a sense of duty to carry his family and friends on his back, he was chronically frustrated in both directions. Like the infant who has eaten something not good for him, but who fears his parents' anger or anxiety too much to spit it out or to vomit it up and finally rids himself of it by diarrhea, the patient was unable to get rid of unendurable tension except by expulsive action of the bowel.

Whenever confronted by someone who offered him acceptance (mother, girl friend) at the cost of pursuing some of his own wants (freedom of selecting friends, deciding when to make sexual advances), he tried to comply. Inevitably, the reaction to frustration occurred.

Both acute and chronic diarrhea are frequently found in emotional situations where the appropriate response would be one of angry rebellion, the throwing off of an unwelcome task or relationship. In a high proportion of cases, the diarrhea can be successfully treated by enabling the patient to find a better solution to his emotional problems.

BOOK NOTICES

The Mentally Ill in America. By ALBERT DEUTSCH. Price $5.50. Pp. 555. New York, Columbia University Press, 1949.

This comprehensive, carefully documented book has been improved and enlarged in this revised edition. The development of graduate psychiatric education, which is directly related to the care of the mentally ill, might well have been included but despite this and a few minor omissions, this outstanding and definitive book remains on the list of required reading for all psychiatrists. (K.A.M.)

New Ways in Discipline. By DOROTHY WALTER BARUCH. Price $3.00. Pp. 380. New York, Whittlesey House, 1949.

This interesting and easy-to-read book is a thought-provoking, pattern-setting presentation of how to improve personal relationships by encouraging properly channeled expressions of hostility. The author succeeds remarkably well in reiterating key ideas without causing irritation. The reporting of conversations between children and adults, clever line drawings by Lois Fisher, the unusual arrangement of type and white space emphasize her thesis. This book blueprints ways to accept-with-understanding the verbal, literary and artistic release of hurt, angry and fearful feelings. (Catharine W. Menninger)

Problems of Early Infancy. MILTON J. E. SENN, ed. Price $1.00. Pp. 120. New York, Josiah Macy Jr. Foundation, 1949.

These papers presented at the 1948 Macy Foundation Conference are concerned with the psychosomatic relationship between mother and child in pregnancy and birth. There are two papers reporting clinical observations and experiences in natural childbirth. A number of discussions of evidences of the influence of the personality development and emotional experience of the mother upon conception and the subsequent development of her child are included. A supplement consists of brief reports on the behavior and development of European children during and immediately following the war. (Margaret B. McFarland, Ph.D.)

David B. Rotman, M.D.: Addresses and Papers, 1934–1948. AGNES A. SHARP, ed. Pp. 205. Chicago, The Psychiatric Institute of the Municipal Court of Chicago, 1948.

These papers and addresses are Doctor Rotman's effort to extend and explain to lay groups the application of psychiatric knowledge to social issues. The superficial handling of such complex problems as crime, alcoholism, and delinquency, and his self-regretted lack of psychoanalytic methods of study, are unfortunate considering that he had so much to contribute from his varied and vast experiences. It seems almost characteristic that he would, however, choose to enlighten those of his community who made possible, and could insist on the continuation of, his type of work. (Jack A. Dunagin, M.D.)

La Lutte Contre La Folie. By LOUIS MARS, M.D. Pp. 133. Port-au-Prince, Haiti, Imprimerie de l'etat, 1947.

Although this book is primarily a part of Doctor Mars' singlehanded fight for improved hospital facilities and the establishment of mental hygiene clinics and child guidance centers in Haiti, it is, at the same time, invaluable to the student of comparative psychiatry. The first part of the book, divided into four sections, contains a sketch of mental diseases which is rich in insights derived from psychiatric anthropology. The fifth part, which constitutes one half of the book, is a priceless contribution to comparative psychiatry. It contains minutely complete case-histories and clinical records of several Haitian patients, complete with references to the cultural factors responsible for certain delusions. (George Devereux, Ph.D.)

Pastoral Counseling. By SEWARD HILTNER. Price $3.00. Pp. 286. New York-Nashville, Abingdon-Cokesbury Press, 1949.

This is probably the most systematic exposition of the aims, dynamics, and techniques of pastoral counseling that has yet appeared. Its theses are concretely illustrated with many specific examples and documented with many footnotes and references to psychiatric literature. Some psychiatrists will feel that it leans too heavily on the work of Carl Rogers and Karen Horney; there are far more references to both of these writers than to any other, including Freud. (K.A.M.)

Individual Behavior. By DONALD SNYGG AND ARTHUR W. COMBS. Price $3.50. Pp. 386. New York, Harper & Bros., 1949.

Theory formation is a most needed activity in the social sciences. In this sense and in the fact that the authors attempt to push a point of view as far as they can, the book is a worthwhile contribution. However, the book raises the question whether an adequate theory can be based on a unitary postulate and one that is as extreme as that defined by the authors. Snygg and Combs say, "All behavior, without exception, is completely determined by and pertinent to the phenomenal field of the behaving organism. . . . By the phenomenal field we mean the entire universe, including himself, as it is experienced by the individual at the instant of action." In other words, "The basic human need is: the preservation and enhancement of the phenomenal self." (Bernard Steinzor, Ph.D.)

The Present State of American Sociology. By EDWARD SHILS. Price $.75. Pp. 64. Glencoe, Ill., The Free Press, 1948.

An appraisal of American sociology has just been made available that is at the same time discriminating and panoramic, thoughtfully constructive and incisively critical, brief, thorough and readable. Originally written to acquaint British readers with significant trends in American sociology, it offers an admirable means for communicating these developments to American non-sociologists. The jargon which clutters so much sociological writing is little in evidence, and footnotes provide fairly extensive bibliographic references. Freudian psychiatrists and Lewinian psychologists will be especially interested in the consideration of sociology's relation to their respective theories. American sociologists can also profit from a reading of this pamphlet, for Shils is far ahead of most of them in his grasp of what American sociology is and of what it may become. (Louisa P. Holt, Ph.D.)

Opiate Addiction. By ALFRED R. LINDESMITH. Price $3.00. Pp. 238. Bloomington, Indiana, Principia Press, Inc., 1947.

The data which are the basis of this sociological survey of the problem of opiate addiction in the United States were derived from interviewing "sixty to seventy" addicts over the course of a number of years, and from extensive acquaintance with the pertinent literature. The result is not only an excellent description of the process by which an opiate addict becomes "hooked," but a carefully substantiated definition of what constitutes such addiction. The author suggests that the "treatment" of the problem which is urgently required in this country is not primarily medical but social. (Donald J. Watterson, M.D.)

Psychiatry in General Practice. By MELVIN W. THORNER, M.D. Price $8.00. Pp. 659. Philadelphia, W. B. Saunders, 1948.

This reviewer admires the simplicity, courage, and thoughtfulness of the author in writing this long overdue book. It should be useful not only to general practitioners but to psychiatric personnel—aides, nurses, social workers, and psychiatrists as a practical manual and teaching guide. Like all people presenting highly technical material to the layman or general practitioner, the author runs the risk of oversimplifying a complicated subject, or else making the material too technical and "over the heads" of the readers. He has done an admirable job in choosing a middle of the road method. (H. Harlan Crank, M.D.)

Personality in Handwriting. By ALFRED O. MENDEL. Price $3.50. Pp. 375. New York, Stephen Daye Press, 1947.

The author makes a serious attempt to raise the status of handwriting analysis from the depths of charlatanism to the level of psychological science. As with most graphologists, however, his conclusions are based upon analogy and rather flimsy empiricism. A well-known personality type, Hitler for example, shows certain peculiar characteristics in his handwriting. Therefore if your writing reveals the same signs, you are assigned character traits similar to Hitler's. Mendel has organized his book in a manner which permits investigation of graphological hypotheses without burdensome study of intricate techniques. He has adapted the methods of European graphologists to American handwriting, particularly as it is learned from the Palmer method. (William H. Brown)

Sociometry in Group Relations. By HELEN HALL JENNINGS AND OTHERS. Price $1.25. Pp. 85. Washington, D. C., American Council on Education, 1948.

While considerable scepticism must greet many of the esoteric and extravagant pronouncements of J. L. Moreno and his disciples, there is nevertheless something of value in what they have to say. In *Sociometry and Group Relations* a clear distillation of valuable elements is to be found. Although this pamphlet is written primarily for teachers, I believe few hospital psychiatrists could read it without being tempted to try out these excellently described techniques in dealing with patient groups. If we agree that the classroom should provide conditions for healthy emotional development, perhaps it is also true that the psychiatric ward should provide

such conditions; this pamphlet indicates certain steps which may be taken in that direction. (Louisa P. Holt, Ph.D.)

Searchlights on Delinquency. K. R. EISSLER, ed. Price $10.00. Pp. 456. New York, International Universities Press, Inc., 1949.

An editorial note advises that this book is not a uniform approach nor the viewpoint of any particular psychoanalytic school, but rather a representative cross-section of psychoanalytic theory and treatment of delinquency. Among the many outstanding and provocative papers are contributions by Margaret Mahler, S. A. Szurek, Anna Freud, Kate Friedlander, Adelaide Johnson, Fritz Redl, and Paul Bergman. Papers deal with adult criminology at one extreme and neurotic children with antisocial behavior at the other. This is mentioned, not as criticism, but as a means of emphasizing the wider contributions of this book to psychoanalytic theory and treatment than the title implies. (Edwin S. Kessler, M.D.)

Methods of Psychology. By T. G. ANDREWS. Price $5.00. Pp. 716. New York, John Wiley and Sons, Incorporated, 1948.

Students of psychology have long needed a book which, as this one does, stresses the methods appropriate to scientific study in such areas as learning, motivation, perception, and emotion, rather than the facts already discovered in these areas. Twenty-one more or less discrete areas are each covered by a chapter written by a specialist and an introductory chapter by the editor attempts to skim the important general issues of psychological methodology. Though its coverage of several areas is too thin to be adequate and though its concern with general principles of methodology and experimental design is all too brief this book should prove really useful in teaching experimental psychology as a supplement to a basic text such as Woodworth's "Experimental Psychology." (Herbert J. Schlesinger)

Studies in Analytical Psychology. By GERHARD ADLER. Price $4.00. Pp. 250. New York, W. W. Norton & Co., Inc., 1948.

A prominent Jungian here presents a collection of theoretical and clinical essays. Many of Jung's concepts and mystical notions are expounded, with numerous case illustrations. The book is frequently interesting, but will be convincing principally to those who do not need to be persuaded by logical means. An example will illustrate the kind of reasoning employed: "the discovery of the archetypes as the a priori determining constituents of all experience means . . . that the individual, through his conscious mind, has to experience, to choose and to decide for himself." (Robert R. Holt, Ph.D.)

Language and Language Disturbances. By KURT GOLDSTEIN. Price $8.75. Pp. 374. New York, Grune & Stratton, 1948.

From his treasury of experience in organic brain pathology, Goldstein again brings forth a volume rich in didactic material and clinical insights. This volume on aphasia joins the current standard texts by Wilson, Head, Nielsen, Weisenburg and McBride. It differs in that it does not seek to compile and reconcile views and findings of other researchers. It is more exclusively a one-man exhibit with an organismic centralizing theme which

gives depth perspective beyond the flat nomenclatural approach of his predecessors. Goldstein delineates not aphasic syndromes, but human beings dynamically reacting to awareness of their damaged adaptability generally and language limitations specifically. The orientation is a practical clinical one with effective case documentation. (Walter Kass)

Pediatrics and the Emotional Needs of the Child. HELEN L. WITMER, ed. Price $1.50. Pp. 180. New York, The Commonwealth Fund, 1948.

This selective report of the conference of 44 pediatric professors, child psychiatrists, analysts, and psychiatric social workers held at Hershey, Pa., in 1947 makes fine reading for anyone interested in better and more comprehensive medical care for children. Among the topics thrashed out are: "What have we learned about emotional growth and development?; What can the pediatrician in practice and the pediatric department do in the field of mental health?; and What are the next steps in pediatric teaching and practice in furthering a comprehensive pediatric service?" This book is highly recommended. (Leonard H. Tabaroff, M.D.)

Readings in the Clinical Method in Psychology. By ROBERT I. WATSON. Price $4.50. Pp. 740. New York, Harper & Brothers, 1949.

These 50 papers by prominent practitioners describe the activities of clinical psychologists. The editor offers a useful literature survey at the end of each division. Some of the best contributions are by Shakow, Doll, Frank, Rosenzweig, Blanchard, Blos and Baruch. More than most, this book tries to do justice to the clinical psychologist's therapeutic functions, but the range and depth of the sample given is severely limited. (Lester Luborsky, Ph.D.)

Defining Prestige in a Rural Community. By HAROLD F. KAUFMAN. Price $1.50. Pp. 26. New York, Beacon House, 1946.

The author analyzes the social strata of a rural community consisting of 455 families by means of a prestige rating procedure. This is one method, the author indicates, through which insight may be secured into the dominant social values of a rural community. This study may be of interest only to those concerned with social research. (Edith Beck)

Diagnosis of Antisemitism. Two Essays. By GUSTAV ICHHEISER. Price $1.50. Pp. 27. New York, Beacon House, 1946.

The author attempts to analyze anti-semitism, as a manifestation of social prejudice, in the light of the dynamics and interaction of the divergent groups within our social structure. One may question the content of the analysis itself which, at best, is partial and inconclusive. (Edith Beck)

A Psychiatric and Sociologic Study of a Series of Swedish Naval Conscripts. By MARTIN EKBLAD. Pp. 201. Copenhagen, Ejner Munksgaard, 1948.

The findings in this study refer primarily to all individuals who suffer from any personality deviations other than epilepsy, mental deficiency and gross psychosis. Mainly this monograph consists of statistical comparisons of various items in the histories, service records and observations of Swedish naval conscripts. No attempt is made to determine the etiology of the

disorders in question, and nothing is said about the problem of treatment. The value of this work lies in its support of the general point of view expressed by so many military psychiatrists, that emotionally maladjusted individuals do not do well in military service. (Lewis L. Robbins, M.D.)

Synopsis of Psychosomatic Diagnosis and Treatment. By FLANDERS DUNBAR, M.D. Price $6.50. Pp. 501. St. Louis, C. V. Mosby Co., 1948.

A collection of some interesting case histories, a table of responses for various stages in the growing embryo, a good resume of emotional physiology of the alimentary canal, and reflections statistical and philosophic about several syndromes now thought to offer good psychosomatic hunting, bears the stigma of the hasty collector. The material could be the core of a reflective five-volume work; as it is, the general practitioner for whom it is intended, will wonder more than ever what makes up psychosomatic medicine. (R. L. Sutherland, M.D.)

Psychotherapy, Practice and Theory. By CHARLES BERG, M.D. Price $5.00. Pp. 503. New York, W. W. Norton and Co., 1948.

This is an eminently readable account of the theory and practice of psychoanalysis. The author gives a vivid, colorful exposition of his personal views on the subject and he attacks and offers solutions to the most intricate problems, such as the problem of the constitutional factor in mental disease and the problem of anxiety. The purely clinical part of the book is the most interesting. Although it does not contain the last word on the subject and the theory of psychoanalytic therapy is merely outlined, the book will stimulate discussions both of the clinical and theoretical material. (B. Rubinstein, M.D.)

Modern Pattern for Marriage. By WALTER R. STOKES, M.D. Price $2.25. Pp. 143. New York, Rinehart & Co., Inc., 1948.

This is a simple, clear, instructive book on the sexual hygiene of marriage. The tone and style are good. (K.A.M.)

The Feminine Character. By VIOLA KLEIN. Price $3.75. Pp. 228. New York, International Universities Press, Inc., 1948.

This is a very valuable contribution to our knowledge of women, particularly because it not only describes women from the point of view of one specialized science, but it also integrates the philosophical, biological, psychological and sociological approaches. Each of these sciences is represented by one outstanding person and his or her theories are discussed: for instance, Havelock Ellis, Otto Weininger, Freud, Margaret Mead and others. The author succeeds in making very clear short abstracts and interpretations of the most important aspects of their theories. (Ellen Simon, M.D.)

How to Live Longer. By JUSTUS J. SCHIFFERES. Price $3.00. Pp. 2.55. New York, E. P. Dutton & Co., Inc., 1949.

The former editor of *Modern Medicine* and more recently Director of the Health Education Council and teacher of hygiene at Columbia, here brings together a dozen essays on health topics. These are presented from the

commendable point of view that the realistic wish to live involves a responsibility for learning the real nature of both the internal and external dangers. The tone of the book is excellent and there are many simple lists and tables that will make it useful both in bibliotherapy and in prevention. (K.A.M.)

Public Mental Hospitals in England: A Survey. By DALLAS PRATT. Price $.50. Pp. 38. Philadelphia, The National Mental Health Foundation, 1948.

While the survey is admittedly not statistically complete, it offers a very interesting glimpse into English Mental Hospitals prior to the National Health Service Act. The comparison to American institutions in maintenance, physical plan, available personnel, therapies used, and discharge rates points up already much discussed deficiencies in the American institutions. (Jack A. Dunagin, M.D.)

Deep Analysis. A Clinical Study of an Individual Case. By CHARLES BERG, M.D. Price $3.50. Pp. 254. New York, W. W. Norton Co., 1947.

This is a fascinating book; it reads like a novel. Upon reflection, one wonders whether the author has been able to describe the development of an analytical case photographically. It seems impossible to relate the material of several hundred hours on 254 pages. In this fact lie both the strength and weakness of the book. Its strength is that material only strictly related to the development of the case is reported—and it seems selected material. Its weakness is that one does not know for whom the book was written. It seems too difficult for the lay person and not explicit enough for the student. Written with great intellectual lucidity and charm, once started one cannot put this book away. (Ellen Simon, M.D.)

Occupational Therapy Source Book. By SIDNEY LICHT. Price $1.00. Pp. 90. Baltimore, Williams & Wilkins Co., 1948.

In this collection of original writings of Pinel, Tuke, Rush, Kirkbride, Reid, and others, the author has presented a revealing background for our present day concept in the treatment of mental patients. Attitudes and actions toward mental patients are traced from the first century before Christ to the first part of the present century. The writers of these articles have all emphasized the importance of activity in the treatment of mental patients and for that reason the book should be of particular interest to occupational and recreational therapists. It also has enough historical value to make it of interest to others who work in psychiatry. (Myrl Anderson)